FOR ASSOCIATE USE ONLY:

Check the appropriate box:	Writing No.: _____ Name: _____
☐ Send the insured's check to the agent for delivery.	Address: _____
☐ Contact the associate only if additional information is needed to complete processing of this claim.	_____

AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS (AFLAC)

Attention: Claims Department

Worldwide Headquarters: 1932 Wynnton Road Columbus Georgia 31999-7260

For information or help filing your claim, please call toll-free 1-800-99-AFLAC (1-800-992-3522) or visit our Web site at www.aflac.com.

Toll-free fax number 1-877-44-AFLAC (1-877-442-3522)

ACCIDENT AND DISABILITY CLAIM FORM

If you are filing an accident claim:

1. ***Complete Section A below; be sure to fully explain how you were injured.***
2. ***Send us a copy of the hospital bill; if you were treated in the emergency room or a doctor's office, send us a copy of these bills also.***
3. ***Ask your doctor to complete and sign Section C on the reverse side of this form for all claims and return the form to us at the above address.***

If you are filing for disability benefits

1. ***Complete Section A below; be sure to fully explain how you became disabled.***
2. ***Your employer should answer the questions in Section B below. If you are self-employed:***
   a. ***Answer all questions on this side, and***
   b. ***Send us a copy of your current business license (if required to be licensed) and your most recent quarterly tax returns.***
3. ***Ask your doctor to complete and sign Section C on the reverse side of this form for all claims and return the form to us at the above address.***

SECTION A: PATIENT'S INFORMATION Please answer each question COMPLETELY.

LAST	FIRST	MIDDLE	SEX	BIRTH DATE	MARITAL STATUS	SOCIAL SECURITY #
				/ /	☐ SINGLE ☐ MARRIED ☐ OTHER	

ADDRESS STREET & NUMBER	CITY	STATE AND ZIP CODE	PHONE NUMBER

☐ FULL-TIME STUDENT ☐ PART-TIME STUDENT	RELATIONSHIP TO POLICYHOLDER ☐ SELF ☐ SPOUSE ☐ CHILD ☐ STEPCHILD	POLICYHOLDER	POLICY NUMBER(S)

1. Is claim due to an accident or a disability caused by an accident? ☐ Yes ☐ No Date of accident: ___/___/___
   Describe how accident occurred: _____
   If auto accident, was patient: ❑driver ❑passenger ❑unknown ****If driver, a copy of the police report is required.****
2. Is claim due to disability caused by a sickness? ☐ Yes ☐ No If yes, briefly describe sickness: _____
3. Is claim due to disability related to ☐ pregnancy ☐ complications of pregnancy? Please explain: _____
   Are you pregnant now? ☐ Yes ☐ No Date of delivery or expected date of delivery: ___/___/___

SECTION B: EMPLOYER'S INFORMATION Please complete if filing for disability.

Name and address of patient's employer: _____

Number of hours per week: _____ Monthly salary: _____ Date of hire: ___/___/___ Is disability due to an accident that occurred on the job? ☐ Yes ☐ No If yes, name of Workers' Compensation carrier: _____

Dates unable to work due to accident or sickness: ___/___/___ to ___/___/___ Is he/she still employed? ☐ Yes ☐ No If no, when did employment terminate? ___/___/___ If yes, please indicate date employee is expected to return to work. ___/___/___

Please list job duties employee is unable to perform and the percentage of time this requires daily:

_____ ☐ Less than 60% ☐ 60% or more

_____ ☐ Less than 60% ☐ 60% or more

Was employer authorization to include disability insurance signed? ☐ Yes ☐ No

Does employer pay a portion of the disability premium for the employee? ☐ Yes ☐ No If yes, what percent? _____%

Indicate if employee is exempt from the following deductions: ☐ Social Security ☐ Medicare Does the employee pay disability premiums with pre-tax dollars? ☐ Yes ☐ No If yes, FICA deductions will be deducted from claim payments.

Please note: the employer is required to report disability benefits paid on pre-tax plans on its Form 941 and the employee's Form W-2.

SIGNATURE OF EMPLOYER	TITLE	DATE

PLEASE PRINT FULL NAME	PHONE NUMBER

For your protection California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison..

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ACCIDENT AND DISABILITY CLAIM FORM

SECTION C: DOCTOR'S INFORMATION Please answer each question COMPLETELY.

LAST FIRST MIDDLE	SEX	BIRTH DATE ___/___/___	MARITAL STATUS ☐ SINGLE ☐ MARRIED	SOCIAL SECURITY NO.
ADDRESS STREET & NUMBER	CITY			STATE AND ZIP CODE
RELATIONSHIP TO POLICYHOLDER ☐ SELF ☐ SPOUSE ☐ CHILD ☐ STEPCHILD ☐ OTHER	POLICYHOLDER'S NAME			POLICY NUMBER(S)

DIAGNOSIS	LIST ANY CHRONIC SICKNESS OR DISEASE	ONSET DATE

1. Is this claim for: ☐ An accident ☐ A disability due to an accident? Give date and place of accident. _____
   Give details of the accident:: _____
   If auto accident, was patient: ❑ driver ❑ passenger ❑ unknown
2. Is this claim for ☐ Disability due to sickness? ☐ Disability due to pregnancy? ☐ Disability due to complications of pregnancy?
   Date of delivery or expected delivery: ___/___/___ Type of delivery: ☐ Vaginal ☐ Caesarean
   If filing for complications, please explain: _____
3. Is this accident/sickness covered by Medicaid/state aid? ❑Yes ❑ No
4. Symptoms first occurred on: ___/___/___ Patient first consulted you for this condition on ___/___/___.
5. Has patient ever had same or similar condition? ❑ No ❑ Yes If yes, state when and describe: _____
6. Referring physician (name/address): _____
7. If patient was hospitalized for this condition, list dates and name(s) of hospital(s): _____

DATES OF SERVICE	PLACE OF SERVICE (IP/OP)	PROCEDURE DESCRIPTION	# UNITS	CODE: CPT/HCPCS/RVS	DIAGNOSIS CODE ICD.9	CHARGE
					TOTAL	$

If patient is disabled, please answer Questions 5 through 8:

8. If patient is disabled, give dates of disability: from ___/___/___ to ___/___/___
9. What specific job duties is patient unable to perform? _____
10. Is patient ❑ Ambulatory? ❑ Bed-confined? ❑ House-confined? ❑ Hospital-confined? ❑ Other? _____
11. If retired or employed less than 30 hours per week, which activities of daily living (ADLs) is patient unable to perform?
    Check all that apply: ☐ Continence ☐ Transferring ☐ Dressing ☐ Toileting ☐ Eating ☐ Bathing (PA only)

Date: _____, _____ Signed: _____
(Attending Physician)

Name of attending physician (please print): _____
Tax ID or Social Security Number

(Street Address) (City or Town) (State and Zip Code) (Area Code Phone)

I hereby request and authorize any health care provider to furnish to AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS (AFLAC) or its representative any and all medical information concerning any sickness or injury I may have suffered, including HIV testing and the diagnosis and treatment of communicable diseases, ARC, AIDS, chemical dependency or psychiatric sickness.

Persons signing may receive a copy of this authorization. Any copy of this authorization shall have the same authority as the original.

SIGNATURE OF PATIENT; IF MINOR, PARENT MUST SIGN DATE

If signed on behalf of another, state the relationship. _____(Only if patient is unable to sign)
(Expires six months from date stated above unless indicated otherwise or revoked earlier.)

For your protection California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.